

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0002923</u></p> <p>Facility Name: <u>Heartland Manor Nursing Center</u></p> <p>Address: <u>410 Northwest Third, PO Box 10</u> <u>Casey</u> <u>62420</u> <small>Number City Zip Code</small></p> <p>County: <u>Clark</u></p> <p>Telephone Number: <u>(217) 932-4081</u> Fax # <u>(217) 932-4922</u></p> <p>HFS ID Number: <u>370860567001</u></p> <p>Date of Initial License for Current Owners: <u>12/18/1964</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 789-7700</u> Email Address: <u>mike.martin@rsmi.com</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2007</u> to <u>06/30/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u></td> </tr> </table> <p align="right"> (Date) _____ (Date) _____ </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>							

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,093	834	810	2,737	8
9	SNF/PED					9
10	ICF	10,486	6,169	33	16,688	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,579	7,003	843	19,425	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.61%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 12/16/1964

J. Was the facility purchased or leased after January 1, 1978?
YES Date N/A NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 28 and days of care provided 810

Medicare Intermediary Wisconsin Provider Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/08 Fiscal Year: 06/30/08

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	188,416	12,057	4,812	205,285		205,285		205,285		1
2	Food Purchase		106,064		106,064		106,064	(11,025)	95,039		2
3	Housekeeping	74,766	16,904	222	91,892		91,892	(18,050)	73,842		3
4	Laundry	75,496	10,879	556	86,931		86,931		86,931		4
5	Heat and Other Utilities			94,840	94,840		94,840		94,840		5
6	Maintenance	42,903	5,679	28,587	77,169		77,169		77,169		6
7	Other (specify):* Waste Removal			6,053	6,053		6,053		6,053		7
8	TOTAL General Services	381,581	151,583	135,070	668,234		668,234	(29,075)	639,159		8
	B. Health Care and Programs										
9	Medical Director			5,813	5,813		5,813		5,813		9
10	Nursing and Medical Records	1,035,304	114,191	3,626	1,153,121		1,153,121		1,153,121		10
10a	Therapy			82,295	82,295		82,295		82,295		10a
11	Activities	43,908	4,184	3,037	51,129		51,129		51,129		11
12	Social Services	25,526		3,037	28,563		28,563		28,563		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,104,738	118,375	97,808	1,320,921		1,320,921		1,320,921		16
	C. General Administration										
17	Administrative	82,305			82,305		82,305		82,305		17
18	Directors Fees										18
19	Professional Services			48,742	48,742		48,742	(6,341)	42,401		19
20	Dues, Fees, Subscriptions & Promotions			12,604	12,604		12,604	(450)	12,154		20
21	Clerical & General Office Expenses	110,777	10,893	13,923	135,593		135,593		135,593		21
22	Employee Benefits & Payroll Taxes			297,971	297,971		297,971		297,971		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,704	5,704		5,704		5,704		24
25	Other Admin. Staff Transportation			503	503		503		503		25
26	Insurance-Prop.Liab.Malpractice			69,483	69,483		69,483		69,483		26
27	Other (specify):*										27
28	TOTAL General Administration	193,082	10,893	448,930	652,905		652,905	(6,791)	646,114		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,679,401	280,851	681,808	2,642,060		2,642,060	(35,866)	2,606,194		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Manor Nursing Center

#0002923

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			89,426	89,426		89,426		89,426			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,482	12,482		12,482	(8,996)	3,486			32
33	Real Estate Taxes			4,685	4,685		4,685	(4,685)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,573	10,573		10,573		10,573			35
36	Other (specify):*											36
37	TOTAL Ownership			117,166	117,166		117,166	(13,681)	103,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,316	3,000	34,316		34,316		34,316			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,353	54,353		54,353		54,353			42
43	Other (specify):* Nonallowable costs			67,103	67,103		67,103	(67,103)				43
44	TOTAL Special Cost Centers		31,316	124,456	155,772		155,772	(67,103)	88,669			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,679,401	312,167	923,430	2,914,998		2,914,998	(116,650)	2,798,348			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,025)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,014)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,572)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,341)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,146)	43		24
25	Fund Raising, Advertising and Promotional	(37,789)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,115)	43		28
29	Other-Attach Schedule See P5A	(27,648)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,650)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (116,650)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Gain on Sale of Asset	\$ (42)	43	1
2	Medicare Ancillary Expense	(1,997)	43	2
3	Finance Charges	(2,424)	32	3
4	Non-care Real Estate Taxes	(4,685)	33	4
5	Revenue Offset to Housekeeping	(18,050)	3	5
6	Nonallowable dues	(450)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,648)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Manor Nursing Center# 0002923

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,025)	0	0	0	0	0	0	0	0	0	0	(11,025)	2
3	Housekeeping	(18,050)	0	0	0	0	0	0	0	0	0	0	(18,050)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(29,075)	0	(29,075)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,341)	0	0	0	0	0	0	0	0	0	0	(6,341)	19
20	Fees, Subscriptions & Promotions	(450)	0	0	0	0	0	0	0	0	0	0	(450)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(6,791)	0	(6,791)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,866)	0	(35,866)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Manor Nursing Center# 0002923

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,996)	0	0	0	0	0	0	0	0	0	0	(8,996)	32
33	Real Estate Taxes	(4,685)	0	0	0	0	0	0	0	0	0	0	(4,685)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(13,681)	0	0	0	0	0	0	0	0	0	0	(13,681)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(67,103)	0	0	0	0	0	0	0	0	0	0	(67,103)	43
44	TOTAL Special Cost Centers	(67,103)	0	0	0	0	0	0	0	0	0	0	(67,103)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,650)	0	0	0	0	0	0	0	0	0	0	(116,650)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A		N/A		N/A

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V			N/A				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1								\$		1	
2	Marilyn Resch	President	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	2
3	David Belt	Vice President	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	3
4	Ted Perillo *	Secretary	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	4
5	Varcia Vidoni	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	5
6	Linda Fahy	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	6
7	Ginny Collins	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	7
8	Bruce Brown	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	8
9											9
10	* Ted Perillo is the owner of the Pharmacie Shoppe which provides pharmacy services and supplies to the facility.										10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/2007

Ending: 6/30/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1		X	Time Clock	\$132.00	12/2005	\$ 6,915		11/2007	0.0382	\$	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Regents Bank	X	Line of Credit	None	02/2005	250,000	293,126	Demand	0.0475		10,058	6								
7												7								
8	Various	X	Finance Charges								2,424	8								
9	TOTAL Facility Related			\$132.00		\$ 256,915	\$ 293,126			\$	12,482	9								
B. Non-Facility Related*																				
10											(6,572)	10								
11											(2,424)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related					\$	\$			\$	(8,996)	14								
15	TOTALS (line 9+line14)					\$ 256,915	\$ 293,126			\$	3,486	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	N/A	12
Facility is a not-for-profit entity and is exempt from real estate taxes.			
Real estate tax is paid on non-care assets; however, the tax is adjusted out of the cost report per instructions.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT Tom Dunlap, Administrator

TELEPHONE (217) 932-4081 FAX #: (217) 932-4081

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. Facility pays real estate taxes on non-care assets; all		\$ _____	\$ _____
2. <u>costs are adjusted out of cost report.</u>		\$ _____	\$ _____
3. _____		\$ _____	\$ _____
4. <u>03-11-19-08-203-046</u>	<u>Lots 8&9 Sturdevant & Goble Addn.</u>	\$ <u>302.16</u>	\$ _____
5. <u>03-11-19-08-203-047</u>	<u>Lots 4&5 Sturdevant & Goble Addn.</u>	\$ <u>1,433.66</u>	\$ _____
6. <u>03-11-19-08-203-049</u>	<u>Lot 2 Sturdevant & Goble Addn.</u>	\$ <u>1,564.58</u>	\$ _____
7. <u>03-11-19-08-203-050</u>	<u>Lots 3&6 Sturdevant & Goble Addn.</u>	\$ <u>2,054.30</u>	\$ _____
8. <u>03-11-19-08-203-051</u>	<u>Lots 6&7 Sturdevant & Goble Addn.</u>	\$ <u>974.86</u>	\$ _____
9. <u>03-11-19-08-203-052</u>	<u>Lot 10 Sturdevant & Goble Addn.</u>	\$ <u>555.60</u>	\$ _____
10. _____		\$ _____	\$ _____
TOTALS		\$ <u>6,885.16</u>	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? See Above YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007 Ending:

06/30/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>152,472</u>	<u>1964</u>	<u>\$ 24,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	152,472		\$ 24,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	78	1964	1964	\$ 385,838	\$	25	\$	\$	\$ 385,838	4
5		1966	1966	8,491		25			8,491	5
6		1970	1970	3,400		25			3,400	6
7		1972	1972	11,798		25			11,798	7
8	21	1996	1996	828,949	20,724	40	20,724		248,689	8
	Improvement Type**									
9	Building improvements		1973	7,123		10			7,123	9
10	Building improvements (less disposition of \$1,076 in '07-'08)		1974	27,871		14-30			28,947	10
11	Building improvements (less disposition of \$1,773 in 2005-06)		1975	5,291		10-30			5,291	11
12	Building improvements		1976	1,607	28	10-30	28		1,578	12
13	Building improvements		1977	1,808		7			1,808	13
14	Building improvements (less disposition of \$4,880 in 2006-07)		1978	1,281		5-15			1,281	14
15	Building improvements		1979	949		10			949	15
16	Building improvements		1980	5,829		7			5,829	16
17	Building improvements		1981	1,376		7			1,376	17
18	Building improvements		1982	11,926		3-30			11,926	18
19	Building improvements		1983	6,263		5			6,263	19
20	Building improvements (less disposition of \$1,974 in 2004-05)		1984	16,740		5-15			16,740	20
21	Building improvements (less disposition of \$480 in 2005-06)		1985	5,320		5-15			5,320	21
22	Building improvements (less disposition of \$28,007 in 2005-06)		1986	17,785		10-20			17,785	22
23	Building improvements (less disposition of \$157 in 2006-07)		1987	27,530		5-15			27,530	23
24	Building improvements		1988	4,282		12-15			4,282	24
25	Building improvements (less disposition of \$610 in '07-'08)		1989	2,259		15			2,869	25
26										26
27	Building improvements (less disposition of \$2,795 in 2002-03)		1991	631		10			631	27
28	Heating/air system		1992	80,277	4,014	20	4,014		68,906	28
29	Building improvements		1992	3,084		10			3,084	29
30	Building improvements		1992	2,168		10			2,168	30
31										31
32	Building improvements		1992	647		10			647	32
33	Building improvements		1992	4,263	72	15	72		4,263	33
34	Ceiling/floor		1992	49,923	2,496	20	2,496		38,383	34
35	Sprinkler system		1992	60,121	3,006	20	3,006		47,095	35
36	Storage shelving		1993	4,090		10			4,090	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Storage shelving	1993	\$ 1,003	\$	10	\$	\$	\$ 1,003	37
38	Resident security system	1993	3,909	195	20	195		3,011	38
39	Cabinets	1993	42,611	2,311	15-20	2,311		33,426	39
40	Heating/air/tubs	1993	29,226	1,461	20	1,461		21,188	40
41	Fire alarm system	1993	12,350	618	20	618		10,449	41
42	Plumbing and water system	1993	8,684	434	20	434		6,620	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493	517	20	517		7,096	44
45	Building improvements	1995	22,859	801	10-20	801		22,859	45
46									46
47	Architect fees	1996	74,806	1,870	40	1,870		21,058	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		8,596	48
49	Sprinklers	1996	9,774	244	40	244		2,684	49
50	Painting	1996	4,052	101	40	101		974	50
51	General contractor fees	1996	7,841	196	40	196		2,156	51
52	Electrical	1996	18,390	460	40	460		4,847	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		7,441	53
54	Cubicle curtain tracking	1996	742	37	20	37		451	54
55	Room signs	1996	3,331	167	20	167		2,001	55
56	Emergency lighting Jones wing	1996	142	7	20	7		88	56
57	Bath systems Jones wing	1996	8,610	431	20	431		5,169	57
58	Sprinklers Jones wing	1996	340	34	10	34		408	58
59	Security locks Jones wing	1996	1,049	52	20	52		627	59
60									60
61	Call lights Jones wing	1996	1,881	94	11	94		1,128	61
62	Air filtration Jones wing	1996	2,081	104	20	104		1,248	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750	75	10	75		825	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		1,295	65
66	Plumbing	1996	4,640	232	20	232		2,984	66
67	Electrical work (less disposition of \$1,500 in 2005-06)	1996	3,162	233	20	233		2,110	67
68	Flooring	1996	2,400	120	20	120		1,420	68
69	Courtyard	1996	2,766	138	20	138		1,648	69
70	TOTAL (lines 4 thru 69)		\$ 1,919,114	\$ 42,776		\$ 42,776	\$	\$ 1,153,928	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,919,114	\$ 42,776		\$ 42,776	\$	\$ 1,153,928	1
2	Concrete work entrance	1996	1,470	74	20	74		870	2
3	Building appraisal	1997	2,578	64	40	64			3
4	Chapel HVAC	1997	2,324	116	20	116		1,339	4
5	Stained glass window	1997	2,052	103	20	103		1,154	5
6	Steel door	1997	422	21	20	21		236	6
7	Hot water heater-North Wing (less disposition \$3,838 in '06-'07)	1997		79	20	79			7
8									8
9	Hand rails	1997	5,252	263	20	263		2,888	9
10									10
11	Walk in cooler	1997	11,524	576	20	576		6,290	11
12	Fire system work	1997	513	26	20	26		278	12
13	Key pad - security system	1997	360	18	20	18		195	13
14									14
15	Tile flooring - Lobby	1997	900	45	20	45		484	15
16	Hot water heater (less disposition of \$7,318 in 2006-07)	1998		152	20	152			16
17	Bed light installation	1998	1,826	91	20	91		943	17
18	Hand rails	1998	1,413	71	20	71		724	18
19	Sprinklers	1998	708	35	20	35		363	19
20	Generator bypass switch	1998	1,567	78	20	78		797	20
21									21
22	Lighting - kitchen	1998	985	49	20	49		497	22
23	Paging system	1998	516	26	20	26		256	23
24	Room divider remodeling	1998	391	20	20	20		194	24
25	Bathroom lighting	1998	1,090	55	20	55		535	25
26	South wing remodeling	1998	165	8	20	8		8	26
27	Roof over generator room	1998	568	28	20	28		279	27
28	Bathrooms	1998	7,394	370	20	370		3,605	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		2,980	29
30	Fire Alarm System	1999	1,317	66	20	66		609	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		756	31
32		1999	1,760	88	20	88		807	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,974,070	\$ 45,691		\$ 45,691	\$	\$ 1,181,015	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,974,070	\$ 45,691		\$ 45,691	\$	\$ 1,181,015	1
2	Generator panel	2000	2,023	202	10	202		1,737	2
3	Gazebo	2000	2,733	273	10	273		2,050	3
4	Anti-scald valves (2)	2001	655	65	10	65		491	4
5	Shower floor replacement	2001	500	25	20	25		188	5
6	Dining room lights	2001	6,013	301	20	301		2,255	6
7									7
8	Toilet stools & seats	2001	1,414	141	10	141		964	8
9	Parking lot asphalt reseal	2001	5,032	251	20	251		1,698	9
10	Ceramic wall tile	2001	365	18	20	18		123	10
11	Washer & nurse call	2001	485	48	10	48		319	11
12	Bath fans	2001	150	15	10	15		99	12
13	Extend legs on links	2001	607	61	10	61		400	13
14	Wallpaper front lobby	2001	150	15	10	15		101	14
15	Remodel North & South showers	2002	2,332	116	20	116		729	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912	91	10	91		570	16
17	Water heater	2002	4,165	208	20	208		1,267	17
18									18
19	Compressor - freezer	2002	810	81	10	81		479	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		39	20
21	Carpet	2003	2,887	144	20	144		830	21
22	Bypass switch for generator	2003	2,166	108	20	108		559	22
23	Sign	2003	850	85	10	85		453	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		887	25
26	Water Heater	2004	6,548	327	20	327		1,501	26
27	Wireless Monitoring System	2004	4,263	426	10	426		1,918	27
28	Water heater	2004	3,475	174	20	174		767	28
29	Lights, smoke detectors, other	2004	2,562	256	10	256		1,089	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		\$ 2,033,608	\$ 49,363		\$ 49,363	\$	\$ 1,202,528	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,033,608	\$ 49,363		\$ 49,363	\$	\$ 1,202,528	1
2	Security fence (less disposition of \$2,352 in 2005-06)	2005							2
3	Windows - North wing	2005	5,320	266	20	266		1,042	3
4	Roof air conditioner - dietary	2005	3,997	266	20	266		1,044	4
5	Windows - South Wing	2005	5,499	275	15	275		1,031	5
6	Windows - H Wing	2005	4,132	207	20	207		758	6
7	Handrails	2005	1,375	92	20	92		328	7
8	2 ton compressor	2005	558	37	15	37		112	8
9									9
10	Replace tile in driveway	2005	13,100	655	20	655		1,801	10
11	Generator	2005	20,000	2,000	10	2,000		5,000	11
12									12
13	Roof	2006	10,657	273	39	273		546	13
14	Nurses Station - Countertop	2007	2,736	182	15	182		27	14
15									15
16	Roof Repair	2008	4,587		27.5				16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,105,569	\$ 53,616		\$ 53,616	\$	\$ 1,214,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 353,511	\$ 35,590	\$ 35,590	\$	5-20	\$ 259,709	71
72	Current Year Purchases	3,298	220	220		10	220	72
73	Fully Depreciated Assets	204,956					204,956	73
74								74
75	TOTALS	\$ 561,765	\$ 35,810	\$ 35,810	\$		\$ 464,885	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1994 Ford Van	1995	\$ 41,610	\$	\$	\$	5	\$ 41,610	76
77										77
78										78
79										79
80	TOTALS			\$ 41,610	\$	\$	\$		\$ 41,610	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,732,944	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 89,426	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,426	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,720,712	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	See Schedule 13A attached	292,069	3,197	24,586	87
88					88
89					89
90					90
91	TOTALS	\$ 292,069	\$ 3,197	\$ 24,586	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94	N/A		94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Heartland Manor Nursing Center
Provider #: 00002923
7/1/07 to 6/30/08

Schedule 13A

XI. Ownership Costs Special Services

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

<u>Description & Year Acquired</u>	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Accumulated Depreciation</u>
Aklinski building - 1994	40,045	1,027	13,092
Aklinski concrete work - 1994	3,900	195	2,080
Land - 1994, 1998, 2002, 2005	35,000		
Repp house - 1998	38,500	963	6,378
405 NW 3rd house - 2005	67,629	1,012	3,036
Architect fees for Assisted Living - 2005	2,915		
410 NW 3rd Street - LAND	46,040		
403 NW 3rd Street - LAND	58,040		
TOTALS	<u>292,069</u>	<u>3,197</u>	<u>24,586</u>

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 10,573 Description: Matresses - 5490; Washer/Dryer - 2968; Time Clock - 2115

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of the facility to hire only Certified Nurse Aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	579	\$ 28,509	\$	579	\$ 28,509	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		72	6,236		72	6,236	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,012	47,550		1,012	47,550	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				28,327		28,327	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(2,3)			75	3,000	357	75	3,357	12
13	Other (specify): <u>Oxygen</u>	39(2)					2,632		2,632	13
14	TOTAL			\$	1,738	\$ 85,295	\$ 31,316	1,738	\$ 116,611	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/2007

Ending:

06/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 19,012	\$ 19,012	1
2	Cash-Patient Deposits	11,851	11,851	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,000)	540,434	540,434	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,281	28,281	6
7	Other Prepaid Expenses	30,961	30,961	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 630,539	\$ 630,539	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,151	20,151	12
13	Land	183,625	24,000	13
14	Buildings, at Historical Cost	2,227,320	2,105,569	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	587,036	603,375	16
17	Accumulated Depreciation (book methods)	(1,679,514)	(1,720,712)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Security Dep.)	334	334	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,338,952	\$ 1,032,717	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,969,491	\$ 1,663,256	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 137,041	\$ 137,041	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,848	11,848	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	136,311	136,311	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,385	25,385	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Other Current Liabilities	111,939	111,939	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 422,524	\$ 422,524	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	293,126	293,126	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 293,126	\$ 293,126	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 715,650	\$ 715,650	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,253,841	\$ 947,606	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,969,491	\$ 1,663,256	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,597,057	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,597,057	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(343,216)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (343,216)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,253,841	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,533,715	1
2	Discounts and Allowances for all Levels	(271,856)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,261,859	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,347	6
7	Oxygen	31,097	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 146,444	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,025	14
15	Telephone, Television and Radio	1,884	15
16	Rental of Facility Space	15,377	16
17	Sale of Drugs	29,885	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	862	19
20	Radiology and X-Ray	703	20
21	Other Medical Services	59,026	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 118,762	23
D. Non-Operating Revenue			
24	Contributions	3,004	24
25	Interest and Other Investment Income***	6,572	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,576	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Sch 19A	35,141	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35,141	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,571,782	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	668,234	31
32	Health Care	1,320,921	32
33	General Administration	652,905	33
B. Capital Expense			
34	Ownership	117,166	34
C. Ancillary Expense			
35	Special Cost Centers	101,419	35
36	Provider Participation Fee	54,353	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,914,998	40
41	Income before Income Taxes (line 30 minus line 40)**	(343,216)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (343,216)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Heartland Manor Nursing Center
Provider #: 00002923
7/1/07 to 6/30/08

Schedule 19A

XXil. Income Statement
Line 28 - Other Revenue

<u>Description & Year Acquired</u>	<u>Cost</u>
Hill-rom Settlement	953
Class Action Suit	1,500
Vending Income	679
Medicare Settlement	291
Oil Income	1,183
Cleaning Income	18,050
Lon-term Care Insurance Return	9,574
Miscellaneous Revenue (Sale of scrap, cookbooks, etc.)	2,911
Total agreeing to Page 19 - Line 28	<u><u>35,141</u></u>

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,851	2,080	\$ 45,863	\$ 22.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,728	10,771	221,475	20.56	3
4	Licensed Practical Nurses	12,598	13,866	228,484	16.48	4
5	CNAs & Orderlies	47,513	50,293	511,868	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,067	2,220	24,056	10.84	9
10	Activity Assistants	1,992	2,275	19,852	8.73	10
11	Social Service Workers	1,912	2,135	25,526	11.96	11
12	Dietician					12
13	Food Service Supervisor	1,860	2,080	32,902	15.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,360	19,686	155,514	7.90	15
16	Dishwashers					16
17	Maintenance Workers	3,144	3,379	42,903	12.70	17
18	Housekeepers	8,423	9,249	74,766	8.08	18
19	Laundry	8,129	9,096	75,496	8.30	19
20	Administrator	2,024	2,080	82,305	39.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,318	8,045	110,777	13.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Careplan Coord</u>	1,877	2,135	27,614	12.93	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,796	139,390	\$ 1,679,401 *	\$ 12.05	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	101	\$ 4,812	1(3)	35
36	Medical Director	31	5,813	9(3)	36
37	Medical Records Consultant	12	1,320	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,020	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	3,037	11(3)	44
45	Social Service Consultant	42	3,037	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	264	\$ 19,039		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	25	\$ 1,061	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	13	225	10(3)	52
53	TOTAL (lines 50 - 52)	38	\$ 1,286		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
David J. Sauer	Administrator	0	\$ 75,238	Workers' Compensation Insurance	\$ 33,798	IDPH License Fee	\$		
Tom Dunlap	Asst. Administrator		7,067	Unemployment Compensation Insurance	9,287	Advertising: Employee Recruitment	2,050		
				FICA Taxes	128,358	Health Care Worker Background Check (Indicate # of checks performed <u>16</u>)	256		
				Employee Health Insurance	86,584	Patient Background Checks <u>43</u>	688		
				Employee Meals		Miscellaneous Licenses & Fees	1,213		
				Illinois Municipal Retirement Fund (IMRF)*		Misc. dues & Subscriptions	1,948		
				Life Insurance	37,914	Illinois Health Care Assn Dues	5,009		
				Labs & Physicals	2,030	NAEIR Dues	990		
						Rotary Club, NFIB & Chamber Dues	450		
						Less: Public Relations Expense	(450)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,305	TOTAL (agree to Schedule V, line 22, col.8)		\$ 297,971	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,154
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Mileage	507	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense		
							See Attached Schedule	5,197	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 48,742	TOTAL		\$	TOTAL	\$ 5,704	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Heartland Manor Nursing Center
Support Schedules
07/01/07 - 06/30/08
Provider # 00002923

Schedule 21 A

Section C - Professional Fees

TOTAL (agrees to Schedule V, line 19, column 3) 48,742

Less:

Non-allowable collection fees (5,634)

Out of Period fees (707)

TOTAL (agrees to Schedule V, line 19, column 3) 42,401

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center# 0002923Report Period Beginning: 07/01/2007Ending: 06/30/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Ill. Health Care Assn. - 5,009
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,943 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,353
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,025
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients?
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: Larsson, Woodyard & Henson CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Audit still in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees